QUESTIONNAIRE ON
ICD-10 TRAINING MATERIALS

Please complete one of these questionnaires for **each** set/type/package of ICD-10 training materials (including those for national versions or clinical modifications) known or used.

Name of WHO Regional office or Collaborating Centre, IFHRO Member Country, or educational institution:_____

Person completing the questionnaire:_____
(Please include contact information at the end.)

Name of training product (if available): _____

Who is the author/developer of the training product? (name and contact details)

_____

_____

_____

Who owns the training product? (name and contact details)

_____

_____

_____

Is there a copyright on the training product?

_____ No

_____ Yes

Is it necessary to obtain a license to use the training product?

_____ No

_____ Yes (please indicate the cost involved and any limitations imposed)

_____

1. **Purpose of training product** (please tick all that apply):

_____ ICD-10 mortality coding training – underlying cause, basic

_____ ICD-10 mortality coding training – underlying cause, advanced

_____ ICD-10 mortality coding training – multiple cause, basic

_____ ICD-10 mortality coding training – multiple cause, advanced

_____ ICD-10 morbidity coding training – learn to code (if the materials relate to a national version or clinical modification, please specify the name of the classification: _____)

_____ ICD-10 morbidity coding training – update from ICD-8/ICD-9 to ICD-10

_____ Orientation to ICD-10 (basic introduction to the classification and its uses, e.g., for doctors, medical/paramedical students, statisticians, other data users)

_____ Awareness building for ICD-10 (advocacy materials, relationship of classification to planning and management, e.g. for high level management)

_____ Other (please specify) _____

2. **Target audience** (please tick all that apply)

_____ Trainers of coders

_____ Coders

_____ Clinicians/doctors

_____ Health record/information students

_____ Medical students

_____ Paramedical students

_____ Statisticians/epidemiologists

_____ Health information analysts

_____ Health information managers/medical record personnel

_____ Health planners and managers

_____ High-level decision makers

_____ Others (please specify) _____

3.   What language/s is this training package available in? _____

_____

4.   Is it possible to obtain translation rights?

_____ No

_____ Yes (please describe the procedure involved, cost, etc.) _____

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5.   Are there any pre-requisites (e.g. for minimum educational level, experience, etc.) required of students using this training product?

_____ No

_____ Yes (please describe)_____

　　　　　_____

6.   What media is used for the training product?

_____ Paper-based

_____ Computer-based

_____ Web-based

_____ Other (please specify)_____

7.   Are there plans for additional media to be used for this training product?

_____ No

_____ Yes (please describe the media planned to be used and the expected date of availability) _____

8.   **What is the usual duration of courses (in hours, days, weeks or months) for which this training product is used?**

_____

9.   **Is there an examination associated with the training product?**

_____ No

_____ Yes (please describe)_____

_____

10.   **How is the training product used?** (please tick all that apply)

_____ face-to-face courses

_____ self-education/learning – distance education (no face to face instructor)

_____ self-education/learning – on site (access to instructor)

_____ Other (please specify) _____

11.   **Is this product available to the public?**

_____ No

_____ Yes (please tick all that apply)

_____ through a distribution centre

_____ on the internet

_____ from the author/producer

_____ from the Collaborating Centre

_____ other (please specify) _____

12.   Is there a charge for the training product?

_____ No

_____Yes (please specify amount and currency)_____

13.   Are there provisions/mechanisms for updating the training product to reflect changes in ICD-10?

_____ No

_____Yes (please describe provisions/mechanisms as completely as possible)

_____

_____

_____

_____

Person Completing the Questionnaire

Name: _____

Designation: _____

Organization: _____

Address: _____

                    _____

                    _____

Telephone no: _____

Fax no: _____

E-mail address: _____

Role in ICD implementation: _____

Return completed questionnaire to: American Health Information Management Association, Attention: Orlanthia Ewing, 233 North Michigan Avenue, Suite 2150, Chicago, Illinois, 60601, USA, to arrive no later than April 8. Thank you.